VACCINE TRANSFER FORM

NORTH DAKOTA DEPARTMENT OF HEALTH (NDDoH)
SFN 53766 (Rev. 05/06)

Transferring Provider

Provider ID Number:_____ Date:_____

Transferring Provider Name:_____

Street Address:_____ City:_____ Zip Code:_____

Contact Person:_____ Telephone No.:_____

Return this form to:
North Dakota Department of Health
Immunization Program
600 East Boulevard Ave
Bismarck, ND 58505-0200
Fax Number: 701.328.2499

1. Complete this form when transferring vaccine.
2. Maintain proper vaccine temperature during transfer.

Vaccine	Receiving Provider Name	Receiving Provider ID Number	Lot Number	Number of Doses
DT				
DTaP				
DTaP/HepB/IPV				
DTap/HIB				
HepA				
HepB				
HIB				
IPV				
Influenza				
MCV-4				
MMR				
MMRV				
PCV-7				
PPV				
Rotavirus				
Td				
Tdap				
Varicella				

Reason for Transfer:_____

_____

_____

Contact the North Dakota Department of Health with any questions or concerns at 701.328.3386 or 800.472.2180